

Flagler Family Medicine, P.A.

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:

| CONDITION | YOU | RELATIVE | CONDITION | YOU | RELATIVE |
|-------------------------|-----|----------|-------------------|-----|----------|
| DIABETES | | | ANEMIA | | |
| HIGH BLOOD PRESSURE | | | LEUKEMIA | | |
| STROKE | | | SICKLE CELL | | |
| HEART ATTACK | | | BLEEDING PROBLEMS | | |
| ASTHMA | | | STOMACH ULCER | | |
| MIGRAINE HEADACHES | | | GALLSTONES | | |
| CANCER | | | SEIZURES | | |
| EMPHYSEMA | | | TUBERCULOSIS | | |
| KIDNEY PROBLEMS | | | ALCOHOLISM | | |
| ARTHRITIS | | | SUICIDE | | |
| GLAUCOMA / EYE PROBLEMS | | | DEPRESSION | | |
| SKIN RASH | | | MENTAL ILLNESS | | |
| OTHER | | | OTHER | | |

OPERATIONS / SURGERIES: _____

OTHER HOSPITALIZATIONS: _____

BLOOD TRANSFUSIONS: _____

MEDICATIONS: _____

ALLERGIES: (Any reaction to any medication of any kind?) _____

OCCUPATION / WORK HISTORY: _____

Any exposure to pesticides, chemicals, or other hazards? YES _____ NO _____

If yes, What kind? _____

Family / Household: (Who lives at home with you?) _____

HABITS: Cigarettes: _____ PPD ___ X _____ years Quit in _____ (year)

Other Tobacco Products? _____ Alcohol _____

Drug Use _____ Caffeine (coffee/colas) _____

Seat Belt Use: Yes: _____ No _____ Exercise: _____

FOR WOMEN ONLY

Age of first menstrual period _____ How many days between periods? _____

How many days does it last? _____ Is bleeding heavy or light? _____

Date of last menstrual period _____ Was it normal? _____

If menstrual periods have stopped, have you had any bleeding since? _____

Any Vaginal Discharge? Yes _____ No _____ Last Pap Smear _____

Method of Preventing Pregnancy _____

Pregnancies _____ Births _____ Abortions/Miscarriages _____

Any other concerns? _____

Name: _____

Social Security: _____

Birth Date: _____